STATE OF UTAH INSURANCE DEPARTMENT

REPORT OF FINANCIAL EXAMINATION

of

MOLINA HEALTHCARE OF UTAH, INC.
dba AMERICAN FAMILY CARE OF UTAH, INC.

of

Midvale, Utah

as of

December 31, 2008

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April 12, 2010

Honorable Neal T. Gooch, Insurance Commissioner
Utah Insurance Department
3110 State Office Building
Salt Lake City, Utah 84114

Pursuant to your instructions and in compliance with statutory requirements, an examination, as of December 31, 2008, has been made of the financial condition and business affairs of:

MOLINA HEALTHCARE OF UTAH, INC.
dba American Family Care of Utah, Inc.
of
Midvale, Utah

hereinafter referred to in this report as the Organization, and the following report of examination is respectfully submitted.

SCOPE OF EXAMINATION

Period Covered by Examination

We performed a single-state examination of Molina Healthcare of Utah, Inc. This examination covers the period of January 1, 2005 through December 31, 2008.

Examination Procedure Employed

We conducted our examination in accordance with the National Association of Insurance Commissioners (NAIC) *Financial Condition Examiners Handbook*. The Handbook requires that we plan and perform the examination to evaluate the financial condition and identify prospective risks of the Organization by obtaining information about the Organization including corporate governance, identifying and assessing inherent risks within the Organization, and evaluating system controls and procedures used to mitigate those risks. An examination also includes assessing the principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation, management's compliance with Statutory Accounting Principles and annual statement instructions when applicable to domestic state regulations.

All accounts and activities of the Organization were considered in accordance with the risk-focused examination process.

Status of Prior Examination Findings

The last exam was completed as of December 31, 2004. Examination findings noted in the prior examination report were corrected during the examination review period.

SUMMARY OF SIGNIFICANT FINDINGS

Items of significance contained in this report are summarized below:

1. The Organization did not file with the Utah Insurance Department (the Department) a copy of its amended bylaws within 60 days after their adoption as required by U.C.A. § 31A-5-203(4). The amended bylaws were filed with the Department on May 27, 2010. (ORGANIZATION HISTORY)

2. The minimum fidelity coverage suggested by the NAIC for the Organization's size and premium volume is not less than $2,500,000. As of the examination date, the Organization participated in fidelity bond coverage of $2,000,000. (FIDELITY BONDS AND OTHER INSURANCE)

3. The Organization reported a healthcare receivable from the Utah Department of Health as a reinsurance recoverable on its NAIC 2008 Annual Statement. The Utah Department of Health is not a qualified reinsurer and the contract with the Utah Department of Health is not a valid reinsurance treaty. The examination determined that it should be recorded as a Health Care Receivable. (REINSURANCE)

4. As of December 31, 2008, the Organization held its statutory deposit for the benefit of all policyholders, pursuant to U.C.A. § 31A-4-108, under a custodial agreement with Wells Fargo Bank, N.A. The custodial agreement did not comply with Utah Administrative Code (U.A.C.) Rule R590-178. The custodial agreement did not contain all of the provisions required by the rule as amended September 19, 2006.

   On February 8, 2010, the Organization revised the custodial agreement to comply with the requirements of U.A.C. Rule R590-178. The board of directors approved the custodial agreement on February 10, 2010. (STATUTORY DEPOSITS)

5. The Organization reported an asset for uncollected premiums and agents' balances in the course of collection of $4,770,850. The examination decreased the asset by $257,609 for an adjusted examination balance of $4,513,241. (COMMENTS ON FINANCIAL STATEMENTS)

6. The Organization reported two Medicare payments, from the Centers for Medicare & Medicaid Services (CMS), which were higher than expected as Premiums received in advance. The funds were placed in reserve pending further

analysis and reconciliation. The examination determined that the amounts should be reclassified as Remittances and items not allocated. (COMMENTS ON FINANCIAL STATEMENTS)

7. Pursuant to U.C.A. § 31A-8-209(1) the Organization is required to maintain minimum capital in the amount of $100,000. The Organization reported total adjusted capital of $6,869,179 and an authorized control level risk-based capital (RBC) requirement of $2,405,458 as of December 31, 2008. The examination determined total adjusted capital to be $6,611,570 as of December 31, 2008. (COMMENTS OF FINANCIAL STATEMENTS)

SUBSEQUENT EVENTS

The Organization and the Department of Health converted the existing Medicaid cost-plus contract to a full risk capitation agreement on September 1, 2009. This conversion reflects Legislative direction to shift the risk of high cost medical cases from the state while adding predictability to the state health budget. The conversion offers the Organization the opportunity for modest premium increases in consideration for assuming the medical cost risk.

During 2009, Molina Healthcare, Inc. migrated its main data processing functions from the facility in Long Beach, California to a new health information technology center in Albuquerque, New Mexico.

During the examination the Chief Financial Officer, Phillip Nowak, resigned.

ORGANIZATION HISTORY

General

The Organization was incorporated under the laws of the state of Utah on May 27, 1994, as a wholly owned subsidiary of Molina Medical Centers (MMC). On May 1, 1996, the Utah Insurance Department (Department) issued the Organization a Certificate of Authority to conduct business as a health maintenance organization (HMO).

Effective January 1, 2000, 100% of the Organization's stock was transferred from MMC to American Family Care, Inc., a holding company now known as Molina Healthcare, Inc. (MHI). The ownership of MHI was identical to the prior ownership of MMC; therefore, no change of control took place as a result of the reorganization. The Organization amended its articles of incorporation on February 25, 2000, and the name of the corporation was changed from American Family Care of Utah, Inc. to Molina Healthcare of Utah, Inc.

The Organization's bylaws, articles of incorporation and minutes of the board of directors meetings and sole shareholder meetings held during the period covered by this examination were reviewed. The Organization amended its bylaws dated February 1, 2009, to change the required fixed number of directors from five (5) to three (3). The

Organization did not file the amended bylaws with the Department within 60 days, as required pursuant to U.C.A. § 31A-5-203(4). The amended bylaws were filed with the Department on May 27, 2010.

Dividends and Capital Contributions

As of December 31, 2008, the number of shares of common stock authorized by the Organization was 100,000 at a par value of $1.00 each. The number of shares issued and outstanding was 100,000. MHI owned 100% of the outstanding shares of common stock.

During 2005, the board of directors declared and the Organization paid $3 million in stockholder dividends. There were no other dividends declared or paid out during the period under examination.

Mergers and Acquisitions

Effective March 3, 2005, the Organization's affiliate Molina Advantage, Inc., a Utah Corporation and licensed third party administrator (TPA), was merged into the Organization which became the surviving corporation. Pursuant to U.C.A. § 31A-16-103(13), and after U.A.C. Rule R590-232 became effective which authorized HMOs to provide services as a TPA of health care benefits, the Commissioner exempted the Organization from the requirements to file an acquisition of control of or merger with domestic insurer statement as required by U.C.A. § 31A-16-103 .

Each of the 100 outstanding shares of Molina Advantage, Inc. was replaced with one-tenth (1/10th) of a share of common stock of the Organization.

CORPORATE RECORDS

In general, the stockholder and board of directors meeting minutes indicated the board and its committees adequately approved and supported the Organization's transactions and events. In accordance with U.C.A. § 31A-2-204(8), the Organization promptly furnished a copy of the previous examination report as of December 31, 2004, dated January 24, 2005, to the board of directors on May 3, 2006.

MANAGEMENT AND CONTROL

The bylaws of the Organization indicated the number of directors shall consist of five (5) persons.

The following persons served as directors of the Organization as of December 31, 2008:

Name and Location	Title and Principal Occupation
Paul J. Muench Midvale, UT	President, Molina Healthcare of Utah, Inc.
Lorin C. Barker, Esq. Salt Lake City, UT	Attorney at Law
Charles A. Coonradt Park City, UT	Executive Vice President – Molina Healthcare, Inc.
George K. Olsen South Jordan, UT	President, IASIS Healthcare – Utah Market
Clayton Wilde, MD Salt Lake City, UT	Medical Doctor Mount Olympus OB/GYN

The following persons served as directors of the Organization as of February 1, 2009:

Name and Location	Title and Principal Occupation
Paul J. Muench Midvale, UT	President, Molina Healthcare of Utah, Inc.
George Goldstein Santa Fe, NM	Molina Healthcare, Inc. Executive VP Emeritus
Andrew Whitelock Long Beach, CA	Director of Government Contracts - Molina Healthcare of California

The Organization's bylaws provide for officers to be of three (3) or more in number. The officers of the Organization as of December 31, 2008, were as follows:

Name	Title
Paul J. Muench	President
Mark Andrews	Secretary
Phillip Nowak	Chief Financial Officer
John Molina	Vice President

As a wholly-owned subsidiary of MHI, which is a Sarbanes Oxley (SOX) compliant entity, the Organization does not have any committees. The Audit Committee, Corporate Governance and Nominating Committee and Compensation Committee are maintained as committees of the MHI board of directors. All of the Organization's committee activities are performed by MHI's committees.

Holding Company

The Organization is wholly-owned and controlled by MHI. An organizational chart illustrating the holding company system follows:

Molina Healthcare, Inc.

- Molina Healthcare of California, Inc.
- HCLB, Inc.
- Molina Healthcare of Michigan, Inc.
- Molina Healthcare of Utah, Inc.
- Molina Healthcare of Washington, Inc.
- Health Care Horizons, Inc.
- Molina Healthcare of New Mexico, Inc.
- Molina Healthcare of Indiana, Inc.
- Molina Healthcare of Texas Inc.
- Molina Healthcare of Ohio, Inc.
- Molina Healthcare of California Partner Plan, Inc.
- Molina Healthcare of Georgia, Inc.
- Molina Healthcare of Nevada, Inc.
- Molina Healthcare Insurance Company
- Alliance for Community Health, LLC (dba Molina Healthcare of Missouri)
- Molina Healthcare of Florida, Inc.
- Molina Healthcare of Virginia, Inc.

FIDELITY BONDS AND OTHER INSURANCE

The minimum fidelity coverage suggested by the NAIC for the Organization's size and premium volume is not less than $2,500,000. As of the examination date, the Organization participated in fidelity bond coverage of $2,000,000. MHI and its subsidiaries, which include the Organization, also had additional insurance protection which included property and liability coverage.

PENSIONS, STOCK OWNERSHIP AND INSURANCE PLANS

As of the examination date, the Organization offered a 401K defined contribution plan to eligible employees, which allowed participants to contribute from 1% to 25% of pretax annual compensation. The Organization made a discretionary matching contribution equal to 100% of the first 4% of participant contributions. In addition, the Organization provided medical, dental, vision, short term disability and life insurance to its eligible employees and their dependents. A deferred compensation plan was also provided to management and key personnel.

TERRITORY AND PLAN OF OPERATION

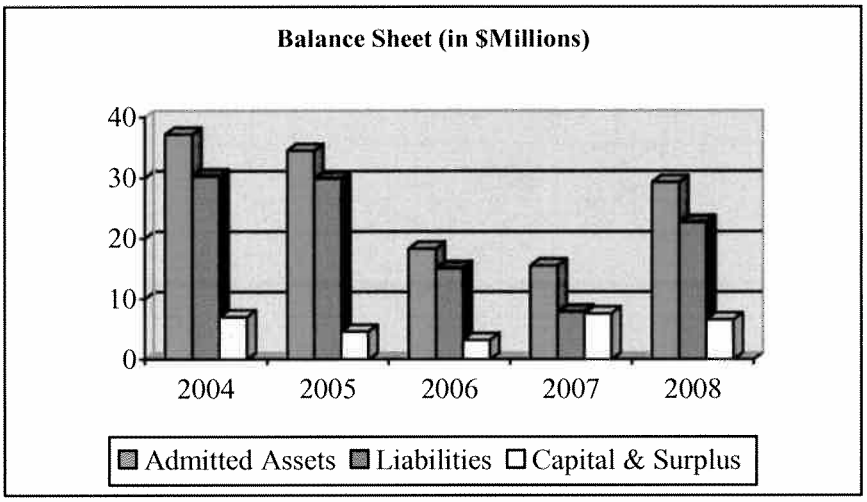
The Organization is authorized to provide health care services as a health maintenance organization (HMO) solely in the state of Utah as of December 31, 2008.

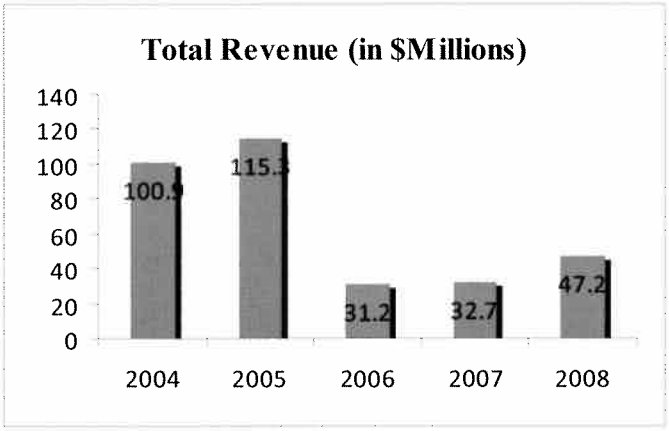
Medicaid: The Organization generates revenues as an administrator through an Administrative Services Contract style plan with the State of Utah's Medicaid program and operates in nineteen (19) of Utah's twenty-nine (29) counties. The State prohibits the Organization and other similar plans from marketing directly to eligible Medicaid beneficiaries, and therefore all new growth comes through Health Program Representatives located within most counties throughout the state. The Organization strives to differentiate itself by applying managed care prior authorization strategies, reducing health risk by health education efforts in several high risk categories, and by quality accreditation programs.

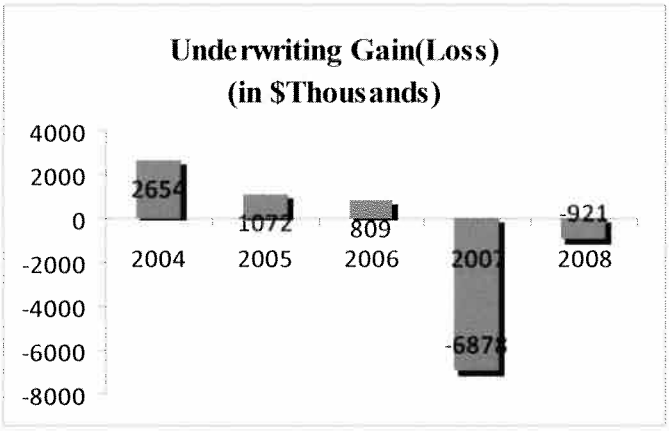
CHIP: The state's Children's Health Insurance Plan (CHIP) program contracts with the Organization on capitation basis and generates profits by implementing utilization controls, health education and frequent use mitigation. The Organization is restricted in how it markets to eligible beneficiaries but has been able to influence membership growth through health fairs, public events and limited promotions. The state now recognizes the Organization as the low cost option and auto assigns all new applicants to it when the applicant has not selected a plan.

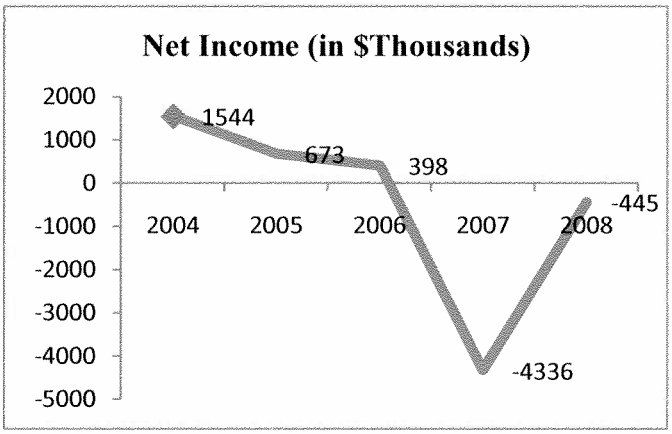
Medicare Advantage: The Organization now operates both a Medicare Advantage Part D Plan and a Medicare Advantage Special Needs Plan. The Special Needs Plan (SNP) can only be marketed to beneficiaries who have qualified for both Medicare and Medicaid. Revenues for these product lines are generated on a risk adjusted capitation basis. The SNP product is limited to a potential pool of 18,000 beneficiaries statewide. The Organization (for Part D) is approved to market in only six counties in the state, including Weber, Davis, Salt Lake, Utah, Iron and Washington counties. The Organization therefore has access to about 5,000 enrollees and currently enrolls 2,437 members at year end 2008.

GROWTH OF ORGANIZATION









LOSS EXPERIENCE

Actuaries from Taylor-Walker & Associates, Inc. reviewed the Organization's actuarial report, claims unpaid, and other claim liabilities as of December 31, 2008. The review included examining the Organization's reserving philosophy and methodologies to determine the reasonableness of the claim liabilities; verifying that claim liabilities include provisions for all components noted in SSAP No. 55, paragraphs 7 and 8, and SSAP No. 54 paragraphs 12, 13, 18 and 19; reviewing historical paid claims and loss ratios; checking the consistency of the incurred-paid data from the Organization's system with the figures reported in the 2008 NAIC Annual Statement; and estimating claims unpaid for the valuation date of December 31, 2008.

Taylor-Walker & Associates, Inc. concluded the Organization followed accurate and appropriate procedures in determining its actuarial liabilities, and the reported reserves were in compliance with statutory requirements.

REINSURANCE

The Organization is a party to a medical excess of loss reinsurance agreement for Medicare on a claims incurred basis with Westport Insurance Corporation. The Organization's basic retention for the Medicare products is $200,000, with a limit of $2,000,000.

The Organization has controls in place to monitor its reinsurance program including the financial condition of its reinsurers. In addition, the Organization utilizes the services of Summit Re as a reinsurance intermediary to solicit, negotiate, and place reinsurance cessions on its behalf. The reinsurance agreement was reviewed and found to comply with Utah reinsurance statutes.

The Organization reported a healthcare receivable from the Utah Department of Health as a reinsurance recoverable on its NAIC 2008 Annual Statement. The examination determined that it should be recorded as a Health Care Receivable. The Utah Department of Health is not a qualified reinsurer and the contract with the Utah Department of Health is not a valid reinsurance treaty.

ACCOUNTS AND RECORDS

The Organization's general ledger was maintained on an accrual basis. The examiner footed the Organization's general ledger trial balance and reconciled it to the balance sheet and income statement contained in the December 31, 2008, Annual Statement. Individual financial statement accounts for the years covered in the examination period were reviewed and reconciled as deemed necessary.

Ernst & Young, an independent certified public accounting firm audited the Organization's records during the period covered by this examination. Audit reports generated by the auditors for the years 2005 through 2008 were made available for the examiner's use.

The information technology and associated systems for the Organization as well as all of the MHI health plans operate on a single platform located at Long Beach, California. During 2009, MHI migrated their main data processing functions from this facility to a new health information technology center in Albuquerque, New Mexico.

MHI exerts control over geographically dispersed subsidiaries through uniform policies/procedures adopting a single IT platform (MAS and QNXT) and centralizing key processes (e.g. claims processing, trade disbursements, bank reconciliations, payroll, cash management, legal, regulatory, finance). Key estimation processes (e.g. IBNR, impairment analyses, legal accruals) are prepared or reviewed by corporate personnel.

The Organization's primary operations and systems responsibilities for accounting, investments, premiums, claims and actuarial operations are located in the MHI corporate offices in Long Beach, California. The primary operations for Provider

Services, Member Services, Utilization Management and Quality Improvement are located in Midvale, Utah.

Some items in the Annual Statements were not prepared in accordance with the NAIC Annual Statement Instructions. We recommend the Organization follow the NAIC Annual Statement Instructions for preparing the Notes to Financial Statements disclosures related to tax sharing agreements with affiliates, Schedule E Part 3, Underwriting and Investment Exhibit – Part 2B, and the Statement of Actuarial Opinion and other items of a similar nature as required. (ACCOUNTS AND RECORDS)

STATUTORY DEPOSITS

The Organization held a statutory deposit, pursuant to U.C.A. § 31A-8-211(1). The examination confirmed that Wells Fargo Bank N.A., under a tri-party agreement with the Department and the Organization, held as a statutory deposit a U.S. Treasury Note with a market value of $576,800 and a par value of $575,000.

As of December 31, 2008, the Organization held its statutory deposit for the benefit of all policyholders, pursuant to U.C.A. § 31A-4-108, under a custodial agreement with Wells Fargo Bank, N.A. The custodial agreement did not comply with U.A.C. Rule R590-178. The agreement did not contain all of provisions required by the rule as amended September 19, 2006.

On February 8, 2010, the Organization revised the custodial agreement to comply with the requirements of U.A.C. Rule R590-178. The board of directors approved the custodial agreement on February 10, 2010.

FINANCIAL STATEMENTS

The following financial statements were prepared from the Organization's accounting records using valuations as determined made during the examination. The accompanying COMMENTS ON FINANCIAL STATEMENTS are an integral part of the financial statements.

MOLINA HEALTHCARE OF UTAH, INC.
BALANCE SHEET
as of December 31, 2008

ASSETS	Net Admitted Assets	Notes
Cash and short-term investments	$ 20,920,814	
Investment income due and accrued	3,234	
Uncollected premiums and agents' balances	4,513,241	(1)(4)
Reinsurance: Amounts recoverable from reinsurers	0	(2)
Current federal and foreign income tax recoverable	2,142,757	
Net deferred tax asset	98,614	
Health care and other amounts receivable	1,628,654	(2)
Total assets	$ 29,307,314	
LIABILITIES, CAPITAL AND SURPLUS		
Claims unpaid	6,108,135	
Unpaid claims adjustment expenses	112,450	
Premiums received in advance	0	(3)
General expenses due or accrued	809,840	
Remittances and items not allocated	14,116,966	(3)
Amounts due to parent, subsidiaries and affiliates	1,124,012	
Aggregate write-ins for other liabilities	424,341	
Total liabilities	22,695,744	
Common capital stock	100,000	
Gross paid in and contributed surplus	6,398,584	
Surplus notes	8,580,000	
Unassigned funds (surplus)	(8,467,014)	(1)(4)
Total capital and surplus	6,611,570	
Total liabilities, capital and surplus	$ 29,307,314	

MOLINA HEALTHCARE OF UTAH, INC.
STATEMENT OF REVENUE AND EXPENSES
for the Year Ended December 31, 2008

Net premium income	$ 47,197,382
Total revenues	47,197,382
Hospital/medical benefits	10,867,918
Other professional services: Compensation to non-physician providers	926,788
Outside referrals	16,826,306
Prescription drugs	10,116,899
Aggregate write-ins for other hospital and medical	-
Less: Net reinsurance recoveries	1,288,407
Total hospital and medical	37,449,504
Claims adjustment expenses	1,412,010
General administrative expenses	9,256,521
Total underwriting deductions	48,118,035
Net underwriting gain or (loss)	(920,653)
Net investment income earned	69,999
Net realized capital gains or (losses)	0
Net investment gains or (losses)	69,999
Net income or (loss) before federal income taxes	(850,654)
Federal and foreign income taxes incurred	(406,043)
Net income (loss)	$ (444,611)

MOLINA HEALTHCARE OF UTAH, INC.
RECONCILIATION OF CAPITAL AND SURPLUS
2005 through 2008

	2005	2006	2007	Per Exam 2008	Notes
Capital and surplus prior reporting year	$ 6,965,206	$ 4,603,634	$4,932,492	$ 7,560,868	
Net income or (loss)	673,447	398,224	(4,335,888)	(444,611)	
Change in net deferred income tax	(28,878)	19,771	65,442	(89,972)	
Change in nonadmitted assets	(6,141)	(128,626)	(103,871)	(414,715)	(1)(4)
Change in surplus notes			8,580,000		
Dividends to stockholders	(3,000,000)				
Aggregate write-ins for gains or (losses) in surplus	0	39,489	(1,577,307)		
Net change in capital and surplus	(2,361,572)	328,858	2,628,376	(949,298)	
Capital and surplus end of reporting year	$ 4,603,634	$ 4,932,492	$ 7,560,868	$ 6,611,570	

COMMENTS ON FINANCIAL STATEMENTS

(1) Uncollected premiums $4,513,241

The Organization reported an asset for uncollected premiums and agents' balances in the course of collection of $4,770,850 due under the Administrative Services Contract from the State of Utah for the Medicaid program. The examiners were able to confirm only $4,513,241 due from the State. The examination non-admitted the unconfirmed amount, causing the asset to decrease by $257,609.

(2) Healthcare and other amounts receivable $1,628,654
Reinsurance: Amounts recoverable from reinsurers $0

The Organization reported amounts due from the Utah Department of Health as Reinsurance: Amounts recoverable from reinsurers, in the amount of $1,563,647 on its NAIC 2008 Annual Statement. The Utah Department of Health is not a qualified reinsurer and the contract with the Utah Department of Health is not a valid reinsurance treaty. The examination determined that it should be reclassified as Healthcare and other amounts receivable, and increased that amount originally reported as $$65,007, by $1,563,647 to $1,628,654.

(3) Remittances and items not allocated $14,116,916
Premiums received in advance $0

The Organization reported two Medicare payments, from the Centers for Medicare & Medicaid Services (CMS), that were higher than expected, as Premiums received in advance. These payments were for the 2008 Mid Year Risk Adjustment and

the 2007 Risk Adjustment Reconciliation. The funds were placed in reserve pending further analysis and reconciliation. The examination determined that the amounts should be reclassified as Remittances and items not allocated.

(4) Capital and surplus $6,611,570

The Organization's capital and surplus was determined to be $257,609 less than the amount reported in the Organization's Annual Statement as of December 31, 2008. The following schedule identifies the examination changes:

Description	Annual Statement Dr (Cr)	Per Examination	Change in Surplus Inc. (Dec.)	Notes
Uncollected premiums and agent's balances in course of collection	$4,770,850	$4,513,241	$ (257,609)	(1)(4)
Total examination changes			(257,609)	
Total capital and surplus per Organization			6,869,179	
Total capital and surplus per examination			$6,611,570	

Pursuant to U.C.A. § 31A-8-209(1) the Organization is required to maintain minimum capital in the amount of $100,000. The Organization reported total adjusted capital of $6,869,179 and an authorized control level risk-based capital (RBC) requirement of $2,405,458 as of December 31, 2008. The examination determined total adjusted capital to be $6,611,570 as of December 31, 2008. The total adjusted capital determined by the examination exceeded the Organization action level RBC requirement of $4,810,916 by $1,800,654. The examination accepted the Organization's authorized control level RBC because adjustments made for examination purposes would not have a significant effect on the RBC requirement.

SUMMARY OF RECOMMENDATIONS

Recommendations related to items of significance contained in this report as noted in the Summary of Significant Finding section, are summarized below:

1. The Organization file all bylaw amendments with the commissioner within 60 days after their adoption to comply with U.C.A. § 31A-5-203(4).

2. The Organization should increase its fidelity bond coverage to a minimum of not less than $2,500,000.

3. Amounts due from the Utah Department of Health pursuant to the CHIP-Molina Healthcare of Utah Contract as "Amounts recoverable from reinsurers" should be reclassified to "Health care and other amounts receivable" pursuant to the NAIC

Annual Statement Instructions and the Accounting Practices & Procedures in future financial statements.

4. The Organization is required maintain its custodial agreements in compliance with U.A.C. Rule R590-178.

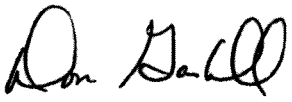
5. It is recommended the Organization write down the uncollected premiums and agents' balances in the course of collection in the amount of $257,609 from $4,770,850 to $4,513,241.

6. It is recommended the Organization classify premium payments in an amount different than the amount billed as "Remittances and items not allocated" per SSAP No. 67, paragraph 9.

ACKNOWLEDGEMENT

Scott Garduno, FSA, MAAA, of Taylor-Walker & Associates, Inc., performed the actuarial phases of the examination. Ben Vettese, Senior IT Examiner, INS Services, Inc., and Paul Berkebile, CISA, CFSA, INS Services, Inc., performed the information systems review. Colette M. Hogan Sawyer, CFE, CPM, PIR, Assistant Chief Examiner, and Donald Catmull, CFE, Co-reviewer, representing the Utah Insurance Department, jointly supervised the examination. Malis Rasmussen, CFE, PIR, Financial Examiner, representing the Utah Insurance Department, participated in the examination. They join the undersigned in acknowledging the assistance and cooperation extended during the course of the examination by officers, employees, and representatives of the Organization.

Respectfully Submitted,



Don Gaskill, CFE
INS Regulatory Insurance Services
Examiner-in-Charge, representing the
Utah Insurance Department